

Alabama Application for Temporary Public Medical Assistance for Evacuees of Hurricane Katrina

This application is for persons displaced from Alabama, Louisiana or Mississippi due to hurricane Katrina.

Please attach a copy of proof of former address (if available) such as driver's license, copy of bills showing previous address, etc.

1. Adult Evacuee. (Children and other evacuees will be listed on Page 2.)

First Name of Evacuee	Middle/Maiden	Last	Social Security Number (if available)
Current County	Are You In Living In A Shelter? Yes <input type="checkbox"/> No <input type="checkbox"/>		Medicare Number (if available)
Current Address			Previous Address
Current City, State, Zip Code			Previous City, State, Zip Code
Phone Number(s): () ()			

2. Is There a Pregnant Woman? Yes ☐ No ☐

Name	Date Baby is Due	Number of Babies in This Pregnancy
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3. Health Insurance. Does anyone applying already have health insurance? Yes ☐ No ☐ If available, we need a copy of your card, front and back.

Policyholder's Name	Insured Person's Name	Insurance Company	Policy #	Group #	Effective Date
1.					
2.					

4. Do You or Anyone In Your Household Have Medicaid or CHIP in Another State? Yes ☐ No ☐ If yes, name of state _____

5. Are You Currently on SSI? Yes ☐ No ☐ Were You Previously on SSI? Yes ☐ No ☐ If yes, date terminated _____

6. Is Anyone Disabled? Yes ☐ No ☐ If yes, list name of person(s) _____

7. Females Aged 19 - 44 May Be Eligible for Family Planning (Birth Control) Services. Do you wish to apply? Yes ☐ No ☐

8. Paid or Unpaid Medical Bills. Did anyone applying have medical expenses (doctor bills, lab work, etc.) in the last 3 months? Yes ☐ No ☐

Name of Evacuee	When Was Care Received?	Name of Evacuee	When Was Care Received?
1.		2.	

For Agency Use Only:	
Medicaid Date Rec'd _____ Accepted _____	ALL Kids Date Rec'd _____ Accepted _____

9. Family Members.

Complete information below on all family members residing at the same address.				Relationship to person on line A.	Are you a U.S. Citizen? Yes or No				
First Name	Middle/Maiden	Last	Social Security Number			Date of Birth	Age	Sex	Race
A				Self					
B				Spouse					
C									
D									
E									
F									

If you have additional household members, attach another sheet of paper.

10. If You Have No Income, Check Here _____**11. Income For You and Your Family.** (Types of earned income are from work and types of unearned income are Social Security, VA, retirement, pensions, etc.)

Name of Person 1.	Gross Income (before anything is taken out)	Source of Earned or Unearned Income
2.		

12. Stepparent. Is there a stepparent in the home? Yes ☐ No ☐ If yes, please complete section below.

Name of Stepparent	Is a Stepparent to:	Name of Stepparent	Is a Stepparent to:

Sign Here:

I certify that all information entered on this application is true, to the best of my knowledge. If I knowingly entered any false statements or left out information asked for on this application, such as income or household members, I commit a crime that is punishable under Federal and/or State law. I understand that this application is for temporary assistance only for ALL Kids and the Alabama Child Caring Program for children under 19 years of age, and for all Alabama Medicaid programs.

Signature of Adult Evacuee

Date

Signature of Adult Evacuee

Date

Mail or fax application to:

Alabama Medicaid Agency
Attn: Hurricane Katrina
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36130-5624
FAX: 334-242-0566